FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039800

Facility Name: Casey Care Center

Address: 5 Doctors Park (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-1064 **Fax #** (618) 242-7559

IDPA ID Number: 391516877001

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) _____

(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606

(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,690	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,911	6,472		25,383	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,911	6,472		25,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.61%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	100,087	7,233	5,132	112,452		112,452		112,452			1
2	Food Purchase		102,389		102,389		102,389	(14,421)	87,968			2
3	Housekeeping	81,480	9,078		90,558		90,558		90,558			3
4	Laundry	23,512	11,051		34,563		34,563		34,563			4
5	Heat and Other Utilities			60,873	60,873		60,873	427	61,300			5
6	Maintenance	26,127		25,227	51,354		51,354	7,473	58,827			6
7	Other (specify):*											7
8	TOTAL General Services	231,206	129,751	91,232	452,189		452,189	(6,521)	445,668			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	778,839	36,466	922	816,227		816,227		816,227			10
10a	Therapy			392	392		392		392			10a
11	Activities	15,439	6,350	2,117	23,906		23,906	11,277	35,183			11
12	Social Services	25,917		1,310	27,227		27,227		27,227			12
13	Nurse Aide Training											13
14	Program Transportation			1,317	1,317		1,317		1,317			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	820,195	42,816	12,058	875,069		875,069	11,277	886,346			16
	C. General Administration											
17	Administrative	88,192		41,382	129,574		129,574	(41,382)	88,192			17
18	Directors Fees							20,636	20,636			18
19	Professional Services			13,887	13,887		13,887	65,128	79,015			19
20	Dues, Fees, Subscriptions & Promotions			7,791	7,791		7,791	1,220	9,011			20
21	Clerical & General Office Expenses	112,836	6,717	20,225	139,778		139,778	34,175	173,953			21
22	Employee Benefits & Payroll Taxes			97,306	97,306		97,306	155,104	252,410			22
23	Inservice Training & Education			316	316		316	1,982	2,298			23
24	Travel and Seminar			6,751	6,751		6,751	10,706	17,457			24
25	Other Admin. Staff Transportation			584	584		584	1,017	1,601			25
26	Insurance-Prop.Liab.Malpractice							58,991	58,991			26
27	Other (specify):*											27
28	TOTAL General Administration	201,028	6,717	188,242	395,987		395,987	307,577	703,564			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,252,429	179,284	291,532	1,723,245		1,723,245	312,333	2,035,578			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Casey Care Center #0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			7,669	7,669		7,669	127,625	135,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,851	13,851		13,851	293,479	307,330			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			415,768	415,768		415,768	(404,033)	11,735			34
35	Rent-Equipment & Vehicles			6,592	6,592		6,592	5,348	11,940			35
36	Other (specify):* Insurance - MIP							16,300	16,300			36
37	**TOTAL Ownership**			443,880	443,880		443,880	38,719	482,599			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							2,521	2,521			39
40	Barber and Beauty Shops			32	32		32		32			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):* Nonallowable costs			7,296	7,296		7,296	(7,296)				43
44	**TOTAL Special Cost Centers**			65,363	65,363		65,363	(4,775)	60,588			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,252,429	179,284	800,775	2,232,488		2,232,488	346,277	2,578,765			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(604)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,960	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(9,379)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(200)	43		18
19	Entertainment				19
20	Contributions	(45)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,157)	43		24
25	Fund Raising, Advertising and Promotional	(2,307)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,983)	43		28
29	Other-Attach Schedule See Sch 5A	(18,096)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,811)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	376,088		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 376,088		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 346,277		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center
Provider #0039800
June 30, 2001

Schedule 5A

Schedule VI - Adjustment Detail
Line 29 - Other

	Amount	Sch V Reference
Miscellaneous Income Offset	(4,086)	21
Interest Income Offset	(169)	32
Out of period professional fees	(13,841)	19
	(18,096)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Casey Care Center

ID# 0039800

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Casey Care Center # 0039800 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	427	0	0	0	0	0	0	427	5
6	Maintenance	0	362	0	0	6,513	0	0	0	0	0	0	6,875	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	362	0	0	6,940	0	0	0	0	0	0	7,302	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	11,277	0	0	0	0	0	0	11,277	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	11,277	0	0	0	0	0	0	11,277	16
	C. General Administration													
17	Administrative	0	12,746	0	51,000	(105,128)	0	0	0	0	0	0	(41,382)	17
18	Directors Fees	0	5,300	0	15,336	0	0	0	0	0	0	0	20,636	18
19	Professional Services	0	13,012	0	0	45,895	20,062	0	0	0	0	0	78,969	19
20	Fees, Subscriptions & Promotions	0	575	0	293	275	77	0	0	0	0	0	1,220	20
21	Clerical & General Office Expenses	0	12,196	0	1,560	24,616	(111)	0	0	0	0	0	38,261	21
22	Employee Benefits & Payroll Taxes	0	20,605	0	105,829	14,249	0	0	0	0	0	0	140,683	22
23	Inservice Training & Education	0	0	0	0	1,982	0	0	0	0	0	0	1,982	23
24	Travel and Seminar	0	3,279	0	1,013	6,414	0	0	0	0	0	0	10,706	24
25	Other Admin. Staff Transportation	0	196	0	0	700	0	0	0	0	0	0	896	25
26	Insurance-Prop.Liab.Malpractice	0	309	0	200	827	58,374	0	0	0	0	0	59,710	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	68,218	0	175,231	(10,170)	78,402	0	0	0	0	0	311,681	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	68,580	0	175,231	8,047	78,402	0	0	0	0	0	330,260	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Casey Care Center # 0039800 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	4,960	2,062	0	0	1,710	118,893	0	0	0	0	0	127,625	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,379)	2,446	0	694	17,553	282,334	0	0	0	0	0	293,648	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	11,735	(415,768)	0	0	0	0	0	(404,033)	34
35	Rent-Equipment & Vehicles	0	0	0	0	5,348	0	0	0	0	0	0	5,348	35
36	Other (specify):*	0	0	0	0	0	16,300	0	0	0	0	0	16,300	36
37	**TOTAL Ownership**	(4,419)	4,508	0	694	36,346	1,759	0	0	0	0	0	38,888	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	2,521	0	0	0	0	0	0	0	0	2,521	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(7,296)	0	0	0	0	0	0	0	0	0	0	(7,296)	43
44	**TOTAL Special Cost Centers**	(7,296)	0	2,521	0	0	0	0	0	0	0	0	(4,775)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,715)	73,088	2,521	175,925	44,393	80,161	0	0	0	0	0	364,373	45

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc. - See attached Schedule 7A	100%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 362	$ 362	1
2	V	11	Activity programming		Center for Residential Management, Inc.	**			2
3	V	17	Management fees	41,382	Center for Residential Management, Inc.	**	54,128	12,746	3
4	V	18	Board fees		Center for Residential Management, Inc.	**	5,300	5,300	4
5	V	19	Professional fees		Center for Residential Management, Inc.	**	13,012	13,012	5
6	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	575	575	6
7	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	12,196	12,196	7
8	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	20,605	20,605	8
9	V	24	Travel & seminar		Center for Residential Management, Inc.	**	3,279	3,279	9
10	V	25	Vehicle expense		Center for Residential Management, Inc.	**	196	196	10
11	V	26	Vehicle, fire & liab. insurance		Center for Residential Management, Inc.	**	309	309	11
12	V	30	Depreciation		Center for Residential Management, Inc.	**	2,062	2,062	12
13	V	32	Interest expense		Center for Residential Management, Inc.	**	2,446	2,446	13
14	Total			$ 41,382			$ 114,470	$ * 73,088	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary service centers	$	Center for Residential Management, Inc.	**	$ 2,521	$ 2,521	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V				**Center for Residential Management, Inc. is				22
23	V				Caravilla Resident Centers, Inc.'s parent company.				23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,521	$ * 2,521	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Caravilla Resident Centers, Inc.	100.00%	$ 51,000	$ 51,000	15
16	V	18	Board fees		Caravilla Resident Centers, Inc.	100.00%	15,336	15,336	16
17	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	293	293	17
18	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	1,560	1,560	18
19	V	22	Emp. benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	105,829	105,829	19
20	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	1,013	1,013	20
21	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	200	200	21
22	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	694	694	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 175,925	$ * 175,925	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 427	$ 427	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	6,513	6,513	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	11,277	11,277	17
18	V	17	Management fees	105,128	Developmental Services of Illinois, Inc.	**		(105,128)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	45,895	45,895	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	275	275	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	24,616	24,616	21
22	V	22	Emp. benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	14,249	14,249	22
23	V	23	Inservice education		Developmental Services of Illinois, Inc.	**	1,982	1,982	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	6,414	6,414	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	700	700	25
26	V	26	Vehicle, fire & liab. insurance		Developmental Services of Illinois, Inc.	**	827	827	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	1,710	1,710	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	17,553	17,553	28
29	V	34	Rent expense		Developmental Services of Illinois, Inc.	**	11,735	11,735	29
30	V	35	Equipment rental		Developmental Services of Illinois, Inc.	**	5,348	5,348	30
31	V								31
32	V								32
33	V								33
34	V				**Developmental Services of Illinois, Inc. is Caravilla				34
35	V				Resident Centers, Inc.'s management company.				35
36	V								36
37	V								37
38	V								38
39	Total			$ 105,128			$ 149,521	$ * 44,393	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 20,062	$ 20,062	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	77	77	16
17	V	21	Office supplies & telephone		Caravilla Charitable Corporation	**	(111)	(111)	17
18	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	58,374	58,374	18
19	V	30	Depreciation		Caravilla Charitable Corporation	**	118,893	118,893	19
20	V	32	Interest expense		Caravilla Charitable Corporation	**	282,334	282,334	20
21	V	34	Rent expense	415,768	Caravilla Charitable Corporation	**		(415,768)	21
22	V	36	MIP insurance		Caravilla Charitable Corporation	**	16,300	16,300	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V				**Caravilla Charitable Corporation and Caravilla				28
29	V				Resident Centers, Inc. have the same parent company.				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 415,768			$ 495,929	$ * 80,161	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Bauer	President	Board Member	None	11,342	2 hrs/mtg.		Board fees	$ 3,458	L18, C8	1
2	Darrell Boehne	Director	Board Member	None	14,048	2 hrs/mtg.		Board fees	752	L18, C8	2
3	Duane Satterwhite	Director	Board Member	None	2,846	2 hrs/mtg.		Board fees	1,954	L18, C8	3
4	Roger Ryan	Vice President	Board Member	None	2,635	2 hrs/mtg.		Board fees	2,165	L18, C8	4
5	Ronald O'Daniell	Director	Board Member	None	2,635	2 hrs/mtg.		Board fees	2,165	L18, C8	5
6	William Armstrong	Treasurer	Board Member	None	2,635	2 hrs/mtg.		Board fees	2,165	L18, C8	6
7	Kay Baker	Secretary	Board Member	None	2,635	2 hrs/mtg.		Board fees	2,165	L18, C8	7
8	Ron Schroeder	Director	Board Member	None	14,048	2 hrs/mtg.		Board fees	752	L18, C8	8
9	Edward Childers	Director	Board Member	None	13,660	2 hrs/mtg.		Board fees	940	L18, C8	9
10	Eugene Humphrey	Director	Board Member	None	4,349	2 hrs/mtg.		Board fees	451	L18, C8	10
11	Orland Bauer	Director	Board Member	None	8,054	2 hrs/mtg.		Board fees	746	L18, C8	11
12	Merla McCloud	Recorder	Administrative	None	15,477	2 hrs/mtg.		Board fees	2,923	L18, C8	12
13								TOTAL	$ 20,636		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	205,860	20	$ 1,284	$	38,690	$ 241	1
2	17	Management fees	Bed days available	205,860	20	288,000		38,690	54,128	2
3	18	Board fees	Bed days available	205,860	20	28,200		38,690	5,300	3
4	19	Professional fees	Bed days available	205,860	20	69,236		38,690	13,012	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	270		38,690	50	5
6	21	Office supplies & telephone	Bed days available	205,860	20	18,491		38,690	3,475	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	41,807		38,690	7,857	7
8	24	Travel & seminar	Bed days available	205,860	20	13,361		38,690	2,511	8
9	25	Vehicle expense	Bed days available	205,860	20	1,044		38,690	196	9
10	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	1,644		38,690	309	10
11	30	Depreciation	Bed days available	205,860	20	10,967		38,690	2,062	11
12	32	Interest expense	Bed days available	205,860	20	13,013		38,690	2,446	12
13	39	Ancillary service centers	Bed days available	205,860	20	13,408		38,690	2,521	13
14										14
15	6	Repairs & maintenance	Direct method						121	15
16	20	Licenses, dues & subscriptions	Direct method						525	16
17	21	Office supplies & telephone	Direct method						8,721	17
18	22	Emp. benefits & payroll taxes	Direct method						12,748	18
19	24	Travel & seminar	Direct method						768	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 500,725	$		$ 116,991	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	235	3	$ 137,000	$	106	$ 51,000	1
2	18	Board fees	Number of beds	235	3	33,999		106	15,336	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	650		106	293	3
4	21	Office supplies & telephone	Number of beds	235	3	3,463		106	1,560	4
5	22	Emp. benefits & payroll taxes	Number of beds	235	3	(6,223)		106	(2,266)	5
6	24	Travel & seminar	Number of beds	235	3	2,246		106	1,013	6
7	32	Interest expense	Number of beds	235	3	1,539		106	694	7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						108,095	10
11	26	Vehicle, fire & liab. insurance	Direct method						200	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 172,674	$		$ 175,925	25

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	205,860	20	$ 2,273	$	38,690	$ 427	1
2	6	Repairs & maintenance	Bed days available	205,860	20	34,653		38,690	6,513	2
3	11	Activity programming	Bed days available	205,860	20	60,000		38,690	11,277	3
4	19	Professional fees	Bed days available	205,860	20	244,200		38,690	45,895	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	1,464		38,690	275	5
6	21	Office supplies & telephone	Bed days available	205,860	20	130,977		38,690	24,616	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	75,816		38,690	14,249	7
8	23	Inservice education	Bed days available	205,860	20	10,547		38,690	1,982	8
9	24	Travel & seminar	Bed days available	205,860	20	34,127		38,690	6,414	9
10	25	Vehicle expense	Bed days available	205,860	20	3,724		38,690	700	10
11	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	4,401		38,690	827	11
12	30	Depreciation	Bed days available	205,860	20	9,100		38,690	1,710	12
13	32	Interest expense	Bed days available	205,860	20	93,395		38,690	17,553	13
14	34	Rent	Bed days available	205,860	20	62,438		38,690	11,735	14
15	35	Equipment rental	Bed days available	205,860	20	28,457		38,690	5,348	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 795,572	$		$ 149,521	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NCS Healthcare, Inc.		X	Hardware/Software	$728.00	10/31/98	$ 29,136	$ 12,517	09/30/03	0.1429	$ 2,129	1
2	Continental Wingate		X	Purchase Facility	$55,560.00	09/19/96	7,402,500	3,250,050	10/01/31	0.0855	278,903	2
3	Lucent Technologies		X	Purchase phone system	$175.00	05/30/97	6,997	1,769	05/31/02	0.1731	185	3
4												4
5												5
	Working Capital											
6												6
7												7
8							Amortization expense				7,525	8
9	TOTAL Facility Related				$56,463.00		$ 7,438,633	$ 3,264,336			$ 288,742	9
	B. Non-Facility Related*											
10							Finance charges				9,379	10
11							Offset of interest income				(8,061)	11
12							Non-allowable finance charges				(9,379)	12
13							Parent and management company allocation				26,649	13
14	TOTAL Non-Facility Related						$	$			$ 18,588	14
15	TOTALS (line 9+line14)						$ 7,438,633	$ 3,264,336			$ 307,330	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		N/A $	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Casey Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039800

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.	N/A		$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	120,000	1994	$ 110,000	1
2					2
3	TOTALS	120,000		$ 110,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1994	1970	$ 2,025,900	$	40	$ 50,648	$ 50,648	$ 341,873	4
5			1998	1998	6,585		40	165	165	577	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	2,586		15	172	172	1,112	9
10	4 doors			1995	715		15	48	48	240	10
11	3 furnaces, 2 a/c's, 3 coils			1995	14,366		15	958	958	4,790	11
12	Windows			1996	20,184		15	1,346	1,346	5,889	12
13	Fire & security alarms			1996	9,560		15	637	637	2,787	13
14	Architecture costs			1996	7,939		15	529	529	2,314	14
15	Asphalt & sidewalk			1996	7,408		15	500	500	2,149	15
16	Roofing			1996	54,022		15	3,601	3,601	15,755	16
17	Fire & security alarm			1997	4,110		15	274	274	1,199	17
18	Paint & wallpaper			1997	3,082		15	205	205	898	18
19	Hinges & doors			1997	6,284		15	419	419	1,833	19
20	Tile			1997	10,739		15	716	716	3,132	20
21	Garage & ground prep			1997	10,489		15	699	699	3,058	21
22	Roofing			1997	7,202		15	480	480	2,100	22
23	Handrail			1997	10,900		15	727	727	3,181	23
24	HVAC			1997	27,483		15	1,833	1,833	8,018	24
25	Dryvit			1997	13,900		15	927	927	4,056	25
26	Plumbing & electrical			1997	21,742		15	1,449	1,449	6,340	26
27	Architecture costs			1997	1,986		15	132	132	578	27
28	Flooring			1997	700		15	47	47	164	28
29	Remodeling of facility			1997	18,980		15	1,265	1,265	4,428	29
30	A/C Timer			1997	2,338		15	156	156	546	30
31	Painting			1997	5,792		15	386	386	1,351	31
32	Landscaping			1997	6,430		15	429	429	1,501	32
33	Lockset, passage set			1997	9,104		15	607	607	2,124	33
34	Electrical service			1997	8,704		15	580	580	2,030	34
35	Ceiling Tiling			1997	3,762		15	251	251	878	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Doors	1997	$ 8,000	$	15	$ 532	$ 532	$ 1,863	37
38	Remodeling of bathroom	1998	4,149		15	277	277	969	38
39	Remodeling of facility	1998	12,277		15	818	818	2,863	39
40	Painting	1998	2,541		15	169	169	592	40
41	Tiling	1998	2,205		15	147	147	515	41
42	Flooring	1998	27,771		15	1,851	1,851	6,479	42
43	Painting and Wallpaper	1998	2,912		15	194	194	679	43
44	Light Fixtures	1998	931		15	62	62	217	44
45	Cabinets/Drawers/Countertops	1998	1,401		15	93	93	326	45
46	Fence	1998	9,613		15	641	641	2,243	46
47	Piping	1998	168		15	11	11	39	47
48	Windows	1998	430		15	29	29	101	48
49	Security	1998	16,030		15	1,069	1,069	3,741	49
50	Architecture Services	1998	270		15	18	18	63	50
51	Signs	1998	3,500		15	233	233	816	51
52	Sidewalk	1998	720		15	48	48	168	52
53	Awning	1998	4,937		15	369	369	903	53
54	Nurse Station Shelving	1998	541		15	36	36	90	54
55	Landscaping	1998	1,614		15	108	108	270	55
56	Carpeting	1998	1,715		15	114	114	285	56
57	Air Conditioner Enclosures	1998	1,806		15	120	120	300	57
58	Sidewalk	1998	3,621		15	242	242	605	58
59	Beauty Shop Renovation	1998	623		15	42	42	105	59
60	Panic Bar	1998	279		15	19	19	47	60
61	Fountain	1998	290		15	20	20	50	61
62	Alarm Door Controller	1998	325		15	22	22	55	62
63	Light & related renovation	1998	963		15	64	64	160	63
64	Landscaping	1998	3,447		15	230	230	575	64
65	Grab bar, sink	1998	401		15	27	27	67	65
66	Annunciator @ nursing station	1999	2,500		15	167	167	417	66
67	Ceiling Tiles	1999	416		15	28	28	70	67
68	Drywall renovation	1999	1,930		15	129	129	322	68
69	Lavatory	1999	300		15	20	20	50	69
70	TOTAL (lines 4 thru 69)		$ 2,441,618	$		$ 78,135	$ 78,135	$ 450,946	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,441,618	$		$ 78,135	$ 78,135	$ 450,946	1
2	Lavatory	1999	324		15	22	22	55	2
3	Lighting	1999	983		15	66	66	165	3
4	Kitchen cabinets	1999	1,291	86	15	86		215	4
5	Asphalt resurfacing	1999	10,259		15	684	684	1,710	5
6	Door frames & accessories	1999	1,238	83	15	83		125	6
7	Insinkerator	1999	962	64	15	64		96	7
8	Painting and remodeling	2000	13,699		15	913	913	1,370	8
9	Hot water line	2000	2,569	86	15	86		86	9
10	Laundry room remodeling	2000	1,400	47	15	47		47	10
11	Molding	2001	773	26	15	26		26	11
12	Molding	2001	631	21	15	21		21	12
13	A/C condensor	2001	1,445	48	15	48		48	13
14	Labor for building improvements	2000	23,139		15	1,543	1,543	1,543	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,500,331	$ 461		$ 81,824	$ 81,363	$ 456,453	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 448,767	$ 5,212	$ 47,362	$ 42,150	5-10 Years	$ 229,106	71
72	Current Year Purchases	10,319	224	564	340	5-10 Years	564	72
73	Fully Depreciated Assets							73
74	Parent and management company allocation			3,772	3,772			74
75	TOTALS	$ 459,086	$ 5,436	$ 51,698	$ 46,262		$ 229,670	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	1997 Ford E150*	1997	$ 21,597	$	$	$	3	$ 21,597	76
77	Resident transportation	1997 GMC Van*	1998	5,315	1,772	1,772		3	4,430	77
78		*Cost allocated between 3 facilities								78
79										79
80	TOTALS			$ 26,912	$ 1,772	$ 1,772	$		$ 26,027	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,096,329	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,669	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 135,294	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 127,625	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 712,150	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Parent and management company allocation:				11,735			6
7	TOTAL				$ 11,735 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 7,123 Description: Dishwasher-$1,661; Water Cooler-$114; Management Co. Allocation - $5,348
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident &	96 Chevrolet Lumina	$ 225.53	$ 2,706	17
18	administrative	91 Ford Taurus Wagon	175.92	2,111	18
19					19
20					20
21	TOTAL		$ 401.45	$ 4,817	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part B MCR supplies	L39, C8					2,521		2,521	13
14	TOTAL			$		$	$ 2,521		$ 2,521	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,763	$ 2,763	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,502)	251,493	251,493	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34	34	6
7	Other Prepaid Expenses	4,180	4,180	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Deposit	887	887	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 259,357	$ 259,357	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		110,000	13
14	Buildings, at Historical Cost		2,032,485	14
15	Leasehold Improvements, at Historical Cost	10,308	467,846	15
16	Equipment, at Historical Cost	44,477	485,998	16
17	Accumulated Depreciation (book methods)	(20,694)	(712,150)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,324	1,324	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in subsidiary	2,485	2,485	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,900	$ 2,387,988	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 297,257	$ 2,647,345	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 311,898	$ 311,898	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,670	69,670	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	1,469,709	1,469,709	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,851,277	$ 1,851,277	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,286	3,264,336	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 14,286	$ 3,264,336	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,865,563	$ 5,115,613	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,568,306)	$ (2,468,268)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 297,257	$ 2,647,345	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Casey Care Center
Provider #0039800
June 30, 2001

Schedule 17A

XV. Balance Sheet

Line 36 - Other	Operating	After Consolidation
Accrued Expense	(6,987)	(6,987)
Trustmark	8	8
Accrued Rent	(53,113)	(53,113)
Accrued Participation	(14,469)	(14,469)
Accrued Insurance	(10,810)	(10,810)
Resident Credit Balances	(80,399)	(80,399)
Due to Related Party	(1,303,939)	(1,303,939)
	(1,469,709)	(1,469,709)

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,494,440)	1
2	Restatements (describe):		2
3	**Prior period adjustments - equity transfer**	462,696	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,031,744)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(339,012)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent & management company allocation**		15
16	Other (describe) **added back in column 7**	(197,550)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (536,562)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,568,306)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,881,903	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,881,903	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,720	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	924	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,644	23
	D. Non-Operating Revenue		
24	Contributions	2,589	24
25	Interest and Other Investment Income***	169	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,758	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending income	1,085	28
28a	Miscellaneous income	4,086	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,171	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,893,476	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	452,189	31
32	Health Care	875,069	32
33	General Administration	395,987	33
	B. Capital Expense		
34	Ownership	443,880	34
	C. Ancillary Expense		
35	Special Cost Centers	7,328	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,232,488	40
41	**Income before Income Taxes (line 30 minus line 40)****	(339,012)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (339,012)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,136	$ 39,600	$ 18.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,312	5,748	73,545	12.79	3
4	Licensed Practical Nurses	12,983	13,846	148,627	10.73	4
5	Nurse Aides & Orderlies	55,835	60,106	432,042	7.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,751	1,949	14,753	7.57	8
9	Activity Director					9
10	Activity Assistants	2,511	2,640	15,439	5.85	10
11	Social Service Workers	3,107	3,308	25,917	7.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,693	15,820	100,087	6.33	15
16	Dishwashers					16
17	Maintenance Workers	2,235	2,271	26,127	11.50	17
18	Housekeepers	12,736	13,656	81,480	5.97	18
19	Laundry	3,861	4,160	23,512	5.65	19
20	Administrator	1,928	2,048	41,138	20.09	20
21	Assistant Administrator					21
22	Other Administrative	1,962	2,060	47,054	22.84	22
23	Office Manager					23
24	Clerical	6,257	6,462	112,836	17.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	872	1,004	6,127	6.10	31
32	Other Health Ca See Sch 20A	5,602	5,932	64,145	10.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,661	143,146	$ 1,252,429 *	$ 8.75	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	112	$ 5,063	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	758	L10, C3	38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant	9	272	L10A, C3	40
41	Occupational Therapy Consultant	4	120	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	12,587	L11, C8	44
45	Social Service Consultant	24	1,310	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	$ 26,274		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Casey Care Center
Provider #0039800
June 30, 2001

Schedule 20A

Schedule XVIII - Staffing & Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Amount	Ave. Hourly Wage
Care Plan Coordinator	1,536	1,658	17,882	10.79
Resident Service Director	4,040	4,248	46,108	10.85
Ancillary Clerk	26	26	155	5.96
	5,602	5,932	64,145	10.81

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Cannon	Administrator	0%	$ 41,138
Parent Company Allocation	See Attached Schedule 21A		47,054
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,192

B. Administrative - Other

Description	Amount
Center for Residential Management - Management fees	$ 41,382
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 41,382

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc.	U/C Consulting	$ 1,250
Mangum, Smietanka & Johnson	Legal	4,264
American Express Tax &		
Business Services	Accounting	2,252
Altschuler, Melvoin		
& Glasser LLP	Accounting	4,650
Lawrence A. Manson	Legal	1,471
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 13,887

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,457
Unemployment Compensation Insurance	18,194
FICA Taxes	95,619
Employee Health Insurance	13,366
Employee Meals	14,421
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	2,282
Employee Uniforms	71
TOTAL (agree to Schedule V, line 22, col.8)	$ 252,410

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,719
Health Care Worker Background Check	
(Indicate # of checks performed 100)	704
Illinois Health Care Association	4,509
Miscellaneous Licenses & Fees	292
Miscellaneous Dues & Subscriptions	210
Management Company Allocation	377
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,011

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,739
Seminar Expense	3,792
Parent & Management Co. allocation	8,926
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,457

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center
Provider #0039800
June 30, 2001

Schedule 21C

XIX. Support Schedules
Section C. Professional Services

TOTAL (agree to Schedule V, line 19, column 3)		**13,887**
Caravilla Charitable Corporation:		
Altschuler, Melvoin & Glasser LLP	Accounting	19,643
American Express Tax & Business Services	Accounting	315
Mangum, Smietanka & Johnson	Legal	104
Management Company Allocation		
American Express Tax & Business Services	Accounting	4,653
Altschuler, Melvoin & Glasser LLP	Accounting	9,754
ADP	Payroll Processing	16,885
Health Outcomes	Consulting	762
Parent Company Allocation:		
American Express Tax & Business Services	Accounting	2,048
Altschuler, Melvoin & Glasser LLP	Accounting	4,058
Mangum, Smietanka & Johnson	Legal	4,376
Lawrence A. Manson	Legal	2,530
Total adjustments & allocations		65,128
TOTAL (agree to Schedule V, line 19, column 8)		**79,015**

SEE ACCOUNTANTS' COMPILATION REPORT

CASEY CARE CENTER
PROVIDER #0039800
6/30/2001

LINE 24 DETAIL:

EDUCATION/SEMINARS	3,642
CNA EDUCATION EXPENSE	150
ADMIN TRAVEL	881
ADMIN MEALS	155
ADMIN LODGING	557
SEMINAR TRAVEL	552
SEMINAR MEALS	2,133
SEMINAR LODGING	461
	8,531
PARENT AND MANAGEMENT COMPANY ALLOCATION	8,926
	$ 17,457

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11						N/A							
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/00 Ending: 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $4,509**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,747** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,035**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,421** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **41%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	100,087	7,233	5,132	112,452	0	112,452	0	112,452
2. Food Purchase	0	102,389	0	102,389	0	102,389	-14,421	87,968
3. Housekeeping	81,480	9,078	0	90,558	0	90,558	0	90,558
4. Laundry	23,512	11,051	0	34,563	0	34,563	0	34,563
5. Heat and Other Utilities	0	0	60,873	60,873	0	60,873	427	61,300
6. Maintenance	26,127	0	25,227	51,354	0	51,354	7,473	58,827
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	231,206	129,751	91,232	452,189	0	452,189	-6,521	445,668
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	778,839	36,466	922	816,227	0	816,227	0	816,227
10a. Therapy	0	0	392	392	0	392	0	392
11. Activities	15,439	6,350	2,117	23,906	0	23,906	11,277	35,183
12. Social Services	25,917	0	1,310	27,227	0	27,227	0	27,227
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	1,317	1,317	0	1,317	0	1,317
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	820,195	42,816	12,058	875,069	0	875,069	11,277	886,346
17. Administrative	88,192	0	41,382	129,574	0	129,574	-41,382	88,192
18. Directors Fees	0	0	0	0	0	0	20,636	20,636
19. Professional Services	0	0	13,887	13,887	0	13,887	65,128	79,015
20. Fees, Subscriptions & Promotion	0	0	7,791	7,791	0	7,791	1,220	9,011
21. Clerical & General Office	112,836	6,717	20,225	139,778	0	139,778	34,175	173,953
22. Employee Benefits & Payroll	0	0	97,306	97,306	0	97,306	155,104	252,410
23. Inservice Training & Education	0	0	316	316	0	316	1,982	2,298
24. Travel and Seminar	0	0	6,751	6,751	0	6,751	10,706	17,457
25. Other Admin. Staff Trans	0	0	584	584	0	584	1,017	1,601
26. Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	58,991	58,991
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	201,028	6,717	188,242	395,987	0	395,987	307,577	703,564
29. Total General Administrative	1,252,429	179,284	291,532	1,723,245	0	1,723,245	312,333	2,035,578
30. Depreciation	0	0	7,669	7,669	0	7,669	127,625	135,294
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	13,851	13,851	0	13,851	293,479	307,330
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	415,768	415,768	0	415,768	-404,033	11,735
35. Rent - Equipment & Vehicles	0	0	6,592	6,592	0	6,592	5,348	11,940
36. Other (specify):*	0	0	0	0	0	0	16,300	16,300
37. Total Ownership	0	0	443,880	443,880	0	443,880	38,719	482,599
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	2,521	2,521
40. Barber and Beauty Shop	0	0	32	32	0	32	0	32
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	58,035	58,035	0	58,035	0	58,035
43. Other (specify):*	0	0	7,296	7,296	0	7,296	-7,296	0
44. Total Special Cost Ce	0	0	65,363	65,363	0	65,363	-4,775	60,588
45. Grand Total	1,252,429	179,284	800,775	2,232,488	0	2,232,488	346,277	2,578,765

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,763	2,763
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	251,493	251,493
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	34	34
7. Other Prepaid Expenses	4,180	4,180
8. Accounts Receivable-Owner/Related Party	-1,303,939	-1,303,939
9. Other (specify):	887	887
10. Total current assets	-1,044,582	-1,044,582
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	110,000
14. Buildings, at Historical Cost	0	2,032,485
15. Leasehold Improvements, Historical Cost	10,308	467,846
16. Equipment, at Historical Cost	44,477	485,998
17. Accumulated Depreciation (book methods)	-20,694	-712,150
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	1,324	1,324
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	2,485	2,485
24. Total Long-Term Assets	37,900	2,387,988
25. Total Assets	-1,006,682	1,343,406
CURRENT LIABILITIES		
26. Accounts Payable	311,898	311,898
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	69,670	69,670
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	165,770	165,770
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	547,338	547,338
LONG TERM LIABILITES		
39.Long-Term Notes Payable	14,286	3,264,336
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	14,286	3,264,336
46.Total Liabilities	561,624	3,811,674
47.Total Equity	-1,568,306	-2,468,268
48.Total Liabilities and Equity	-1,006,682	1,343,406

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,881,903
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,881,903
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,720
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	924
22. Laundry	0
Subtotal - Other Operating Revenue	3,644
24. Contributions	2,589
25. Interest and Other Investments Income	169
Subtotal - Non-Operating Revenue	2,758
27. Other Revenue (specify):	0
28. Other Revenue (specify):	5,171
Subtotal - Other Revenue	5,171
30. Total Revenue	1,893,476
31. General Services	372,357
32. Health Care	1,193,342
33. General Administration	496,661
34. Ownership	241,915
35. Special Cost Centers	213,124
35. Provider Participation Fee	35,686
37. Other	0
40. Total Expenses	2,553,085
41. Income Before Income Taxes	-659,609
42. Income Taxes	0
43. Net Income or Loss for the Year	-659,609

Page

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9
10 Attachment of Real Estate Bill and fill out form

11
12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Casey Care Center** **02:17 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	346,277	equal to	346,277	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	307,330	equal to	307,330	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	135,294	equal to	135,294	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	11,735	equal to	11,735	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	11,940	equal to	11,940	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	392	-392	FAILED	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	2,521	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	452,189	equal to	452,189	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	875,069	equal to	875,069	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	395,987	equal to	395,987	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	443,880	equal to	443,880	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	7,328	equal to	7,328	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	58,035	equal to	58,035	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	699,941	equal to	778,839	-78,898	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	15,439	equal to	15,439	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	25,917	equal to	25,917	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	100,087	equal to	100,087	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	26,127	equal to	26,127	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	81,480	equal to	81,480	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	23,512	equal to	23,512	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	88,192	equal to	88,192	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	112,836	equal to	112,836	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,252,429	equal to	1,252,429	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,063	< or = to	5,132	-69	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	922	< or = to	922	0	O.K.	Pg20 X14..X16+	B. & C.	:7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	12,587	< or = to	2,117	10,470	FAILED	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,310	< or = to	1,310	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	88,192	equal to	88,192	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	41,382	equal to	41,382	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	13,887	equal to	13,887	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	252,410	equal to	252,410	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,011	equal to	9,011	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	17,457	equal to	17,457	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	58,035	equal to	58,035	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	14,421	< or = to	155,104	-140,683	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	14,421	equal to	14,421	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	376,088	equal to	376,088	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	3,264,336	equal to	3,264,336	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	110,000	equal to	110,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,500,331	equal to	2,500,331	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	485,998	equal to	485,998	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	712,150	equal to	712,150	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,568,306	equal to	-1,568,306	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-339,012	equal to	-339,012	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	297,257	equal to	297,257	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1